
MEDICAL NEGLIGENCE LIABILITY UNDER THE CONSUMER PROTECTION ACT: A REVIEW OF JUDICIAL PERSPECTIVE

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ABSTRACT

In modern India, the relationship between doctors and patients has gradually evolved from one based purely on trust to one governed by legal accountability and consumer rights. This article explores the contours of medical negligence liability within the framework of the Consumer Protection Act, focusing on how the law safeguards patients while maintaining respect for medical professionals. The study begins by examining the core legal concepts of consumer, negligence, medical negligence, and deficiency of service, and proceeds to discuss how these notions operate within the healthcare sector. Through the lens of judicial interpretation, the paper analyses the application of the Bolam Test and the doctrine of Res Ipsa Loquitur, both of which guide the courts in assessing whether a medical professional has breached the required standard of care. It also highlights the need for expert medical evidence, which often serves as the backbone for proving negligence in such cases. The article reviews significant Supreme Court judgments, including *Indian Medical*

Association v. V.P. Shantha, *Jacob Mathew v. State of Punjab*, and *Kunal Saha v. AMRI Hospital*, to illustrate how the judiciary has shaped the principles governing medical accountability. Additionally, it outlines the procedure for filing complaints under consumer law, the remedies and compensation available to aggrieved patients, and the defences open to medical practitioners. A comparative perspective with foreign jurisdictions is also undertaken to understand global trends in medical negligence jurisprudence. The research concludes by reflecting on the impact of the Consumer Protection Act, 2019, emphasizing that an effective legal system must strike a fair balance between patient protection and professional autonomy. Ultimately, this article seeks to reaffirm that justice in healthcare is best achieved through a blend of legal precision, ethical duty, and human compassion.

Introduction

India, with its population of over 140 crores, faces a constant struggle to maintain a fair balance between making healthcare accessible to everyone and holding medical professionals accountable for their actions. With one doctor serving roughly 834 people—about 13.01 lakh being allopathic doctors and 5.65 lakh from AYUSH disciplines—medical care stands as one of the most essential pillars of social welfare. In such a vast and diverse country, regulating the medical sector is not only a matter of public policy but also a constitutional and moral duty, aimed at protecting consumer rights and strengthening public trust in healthcare institutions.

The idea of consumer protection is not new to India. Ancient texts like Manu Smriti and Kautilya's Arthashastra (313–289 BC) already spoke of ethical conduct in trade and the responsibility of rulers to prevent exploitation. Kautilya even highlighted the need to regulate medical practice, insisting that physicians act with due skill and caution while treating patients—an early reflection of what we now call medical negligence.

Modern consumer protection in India took shape with the Consumer Protection Act of 1986, later replaced by the Consumer Protection Act of 2019. Often referred to as the Magna Carta of Consumer Rights, it guarantees the right to safety, information, choice, and to be heard. By bringing healthcare within its scope, the law transformed the way medical accountability is viewed, recognizing patients as consumers entitled to seek justice for negligent or deficient medical services.

In recent decades, patient awareness has grown rapidly, and so has litigation relating to medical negligence, lack of informed consent, and breach of confidentiality. This trend mirrors the judiciary's continuing effort—especially by the Supreme Court of India—to interpret the right to health as an essential part of the right to life under Article 21. Yet, while protecting patients, it is equally vital to preserve the professional dignity and independence of doctors. The law must therefore walk a careful line—providing remedies for genuine negligence without discouraging honest medical judgment.

To maintain this balance, a two-fold strategy is necessary. First, the creation of clear, realistic standards of medical care that reflect India's social and economic conditions. Second, encouraging medical practitioners to adopt these standards in their daily work to prevent negligence and build trust. Only through such balance can the traditional tension between

doctors and patients give way to a cooperative relationship based on empathy, ethics, and accountability.

This article explores the scope of medical negligence under the Consumer Protection Act, focusing on issues such as deficiency in service, the Bolam test, *res ipsa loquitur*, and the role of expert evidence. It also explains the procedure for filing complaints, the remedies available to consumers, the defences open to doctors, and compares India's approach with that of other jurisdictions. Finally, it reflects on how the Consumer Protection Act, 2019 has shaped the regulation of medical practice, arguing that real justice in healthcare depends on balancing consumer protection with professional responsibility in a system built on trust and fairness.

Negligence

Negligence, from a legal perspective, is the omission to do that which, in the circumstances, a reasonable person would do, or the doing of that which a reasonable person would not do, such that the other is harmed. To amount to negligence, three essentials must exist side by side—the existence of duty of care, breach of that duty, and resultant damage or injury. Only when these three essentials are satisfied is liability in negligence liable.

For example, if X is held responsible for keeping a hospital's sterilization equipment clean (obvious duty of care) but fails to do so, resulting in infection among patients (breach and resulting harm), the act constitutes negligence. If, however, no harm is caused despite the failure, the liability would not be triggered as damage is the crucial link that makes up the tort.

Under the law of consumer protection, specifically the Consumer Protection Act, 2019, the aforementioned essentials apply equally. A patient who is receiving medical treatment is a consumer of medical services, and any negligence that results in injury or loss as a result of the professional's inability to fulfill reasonably expected standards is a deficiency in service according to Section 2(42) of the Act.

Existence of Duty of Care

The primary requirement is that the defendant owes a legal duty of care to the plaintiff. This duty is not religious, ethical, or moral—it has to be based on law. The doctrine was established in *Bourhill v. Young* (1943), where it was held that an individual cannot be liable for a negligent action unless a legal duty was owed to the injured party.

In medical negligence, this duty comes into existence where a doctor-patient relationship arises. After a patient approaches professional service, the doctor is under a duty to perform with reasonable care, skill, and caution. Likewise, under consumer law, hospitals, clinics, and diagnostic centers are under a statutory duty to deliver safe, effective, and standard medical treatment to their consumers.

Breach of Duty of Care

After establishing the existence of duty, the second vital is breach of duty. Breach is when the defendant cannot act as a reasonable, prudent person in a like circumstance. For medical practitioners, it is not maintaining the standard of care of a competent practitioner in that area.

The Supreme Court in *Jacob Mathew v. State of Punjab* (2005) took the view that medical negligence had to be established by evidence that the doctor has done something which no reasonably skilled medical practitioner would have done under the same circumstances. This ruling stressed that negligence cannot be assumed on the grounds that a treatment had gone wrong; there has to be evidence of departure from ordinary medical practice.

Under consumer protection law, this tenet manifests as standard of care deficiency—whereby the care provider does not furnish care of the sort reasonable to expect of them. Consumer forums routinely base their conclusion on this aspect on medical expert opinions in order to determine if such a failure took place.

Parameters for Determining Standard of Care

The negligence standard of care is not absolute; it depends on the context and nature of the act. Some parameters are taken into account while deciding if due care was exercised:

1. Significance of the Object or Duty Involved – The more significant the act (for example, conducting a life-saving operation), the greater the standard of care expected.
2. Magnitude of Risk – The level of precaution should correspond to the potential risk involved in the act or treatment. Complex and risky medical procedures demand higher diligence.
3. Nature of Consideration or Service – The degree of care also depends on the nature of

professional engagement and the compensation involved. A private hospital charging premium fees would be expected to maintain higher professional standards than a charitable institution.

Resulting Damage

The third requirement is damage, which constitutes the causal connection between the breach of duty and the resulting injury. A cause of action based on negligence exists only if the plaintiff actually sustains harm—physical, mental, or pecuniary. The complainant (patient) must prove that the injury resulted immediately from the professional's breach of duty.

Exceptions are made, though, via the doctrine of *Res Ipsa Loquitur* ("the thing speaks for itself"), which reverses the burden of proof onto the defendant in instances where the negligence can be shown by the inherent nature of the act. For instance, in a sterilization procedure where a surgical mop remained within the patient's cavity, courts established the liability of the hospital because the act itself showed evidence of negligence without the need for elaborate proof.

The rule comes into effect under two circumstances:

1. The defendant's negligence should have caused the injury.
2. The injury should not result from any conduct of the plaintiff or a third person.

This rule is most applicable in medical negligence cases before consumer forums, where patients might not have the technical knowledge to establish negligence. Therefore, when the facts are clear and point towards carelessness, the onus shifts to the medical service provider.

Reasonable Foreseeability

The reasonable foreseeability concept is central to determining liability. It can be defined as whether a reasonable person so placed could have foreseen that their act or default would cause harm. In medical practice, it is determined by professional standards—whether the harm was foreseeable by a qualified medical practitioner in the given circumstances.

Judicial Guidance and Consumer Context

In *Bolam v. Friern Hospital Management Committee* (1957), the court established what has

come to be called the Bolam Test, to the effect that a doctor is not negligent if he acts in line with a practice accepted as proper by a responsible body of medical opinion. This test still directs Indian courts and consumer forums to balance the rights of the patient and professional autonomy.

According to the Consumer Protection Act, courts have increasingly held medical negligence as a case of deficiency in service, allowing patients to recover compensation through an easy and consumer-friendly forum instead of regular civil proceedings.

Historical and Legal Background

Brief History of Medical Negligence in Common Law

The roots of medical negligence can be traced back to English common law, where the general principles of negligence gradually evolved through judicial interpretation. Initially, the responsibility of a medical practitioner was assessed using the “reasonable person” standard—similar to any individual performing a skilled act. However, as the medical profession developed into a distinct and specialized field, courts began to recognize that doctors must be judged by a higher and more professional standard of care expected from a person possessing medical expertise.

A pivotal case that laid the foundation of this doctrine was *Bolam v. Friern Hospital Management Committee* (1957). In this case, the court formulated what came to be known as the Bolam Test, stating that a doctor cannot be held negligent if their conduct is in accordance with a practice accepted as proper by a responsible body of medical professionals skilled in that particular art. This decision was monumental—it balanced professional discretion with patient safety and became the cornerstone of modern medical negligence jurisprudence, influencing not just the United Kingdom but also other common law jurisdictions, including India.

Position of Medical Negligence before the Consumer Protection Act, 1986

Before the enactment of the Consumer Protection Act, 1986, cases involving medical negligence in India were primarily governed by tort law and the Indian Penal Code (IPC). Civil liability arose through civil suits for damages, while criminal negligence was punishable under Section 304A of the IPC, which deals with causing death by a rash or negligent act.

However, these traditional legal avenues were often inefficient, expensive, and inaccessible to ordinary citizens. The tort system required detailed expert evidence and involved lengthy court procedures, which made it impractical for many patients to seek redress. Moreover, India lacked a specialized adjudicatory forum to handle complaints specifically related to professional negligence or deficiency in service. Consequently, medical negligence was largely treated as a private wrong rather than a matter of consumer rights and public accountability.

The absence of a streamlined mechanism meant that many victims were left without adequate remedies, highlighting the urgent need for a dedicated consumer-oriented legal framework.

Enactment of the Consumer Protection Act, 1986 and Its Replacement by the Consumer Protection Act, 2019

The Consumer Protection Act, 1986 (CPA 1986) emerged as a revolutionary piece of legislation aimed at ensuring speedy, simple, and affordable justice to consumers facing unfair trade practices or deficiencies in goods and services. For the first time, it extended legal recognition to patients as “consumers”, thereby allowing them to file complaints against hospitals and medical professionals for negligent or substandard medical care.

The Act established a three-tier redressal mechanism—District, State, and National Consumer Disputes Redressal Commissions—creating an accessible and efficient forum for grievance resolution. Importantly, Section 2(1)(o) of the Act defined service in a manner broad enough to encompass professional services, paving the way for the inclusion of medical practice under consumer protection law.

Recognizing the need to modernize consumer justice mechanisms in a digital era, the Consumer Protection Act, 2019 was enacted to replace the 1986 law. The 2019 Act strengthened consumer rights by introducing product liability, mediation, online complaint filing, and broader definitions of unfair practices. These reforms have made the redressal process more dynamic, transparent, and responsive—particularly in the healthcare sector. The new Act underscores the principles of accountability, transparency, and patient empowerment in medical services.

Expansion of “Service” to Include Medical Services – A Landmark Development

The real transformation in the legal treatment of medical negligence came with the landmark

judgment of the Supreme Court in *Indian Medical Association v. V.P. Shantha* (1995). In this case, the Court held that medical services fall within the scope of “service” as defined under Section 2(1)(o) of the Consumer Protection Act, except in cases where such services are rendered free of charge or under a contract of personal service (for instance, an employer-employee relationship).

This judgment was a turning point in Indian legal history. It recognized patients as consumers entitled to legal protection, while simultaneously ensuring that medical professionals could be held accountable for deficiency in service. The ruling effectively brought hospitals, clinics, and diagnostic centers under the jurisdiction of consumer forums, allowing patients to seek compensation without undergoing lengthy civil trials.

Subsequent cases such as *Spring Meadows Hospital v. Harjol Ahluwalia* (1998) and *Kusum Sharma v. Batra Hospital* (2010) further refined the principles of medical negligence and clarified the standards of professional responsibility expected from healthcare providers. These judicial developments mark India’s shift towards a patient-centric legal framework, emphasizing that healthcare is not merely a profession of trust but also a service governed by legal and ethical accountability.

Consumer’ and ‘Deficiency of Service’ in the Context of Medical Negligence

Definition of ‘Consumer’ in the Medical Field

Under Section 2(7) of the Consumer Protection Act, 2019, a consumer is any person who purchases goods or utilizes services for consideration—be it paid, partly paid, or promised. The term also covers beneficiaries using such services with the permission of the individual employing them.

In the context of healthcare, this implies that a patient paying for medical consultation, treatment, or diagnostic services is a consumer. This construction was conclusively established by the Supreme Court in the seminal case of *Indian Medical Association v. V.P. Shantha* (1995). The Court explained that medical services offered for a charge come under the Consumer Protection Act, thus enabling patients to seek redress for negligence from consumer forums.

Yet the Court set some limits: services rendered entirely at no cost, or under a contract of personal service (like a doctor hired full-time by an association to treat employees), fall outside

this definition. So whenever a patient pays for treatment, the doctor–patient relationship legally becomes a consumer–service provider relationship, so the patient can invoke consumer protection mechanisms in the event of negligence.

Definition of ‘Deficiency of Service’

Section 2(11) of the Consumer Protection Act, 2019, defines the term ‘deficiency’ to mean any fault, imperfection, shortcoming, or inadequacy in the quality, nature, or manner of performance that a person is obligated to sustain under law, contract, or otherwise.

Simply put, a service deficiency takes place when there is an omission of what is reasonably expected in terms of care, skill, or diligence by the service provider. In medicine, it means any professional failure—like misdiagnosis, surgical mistakes, incorrect treatment, or lack of informed consent—that causes injury or damage to the patient.

The Supreme Court, in *Jacob Mathew v. State of Punjab* (2005), asserted that medical negligence has to be measured against the standard of the reasonably competent medical professional under the same or similar circumstances. The Court warned against doctors being judged with hindsight; liability arises only where their action would have fallen below the standard of care which an average skillful doctor would have done.

Spring Meadows Hospital v. Harjol Ahluwalia (1998), where the Supreme Court decided that doctors and hospitals can be held collectively liable for negligent acts of their employees. The Court emphasized that medical professionals have a fiduciary duty of care towards their patients, and the violation of this duty is a deficiency in service under consumer law.

Practical Application under Consumer Law

Enlisting medical services in the definition of “service” in Section 2(42) of the 2019 Act (earlier Section 2(1)(o) of the 1986 Act) was a watershed moment in Indian consumer law. It allowed patients to resort to consumer forums—a speedier, more cost-effective substitute for civil courts—to seek redress for medical negligence.

Consumer courts review allegations of negligence not on the basis of whether a treatment succeeded or failed, but on whether the doctor or hospital acted with reasonable care and skill

in the circumstances. Deficiency would be where treatment is delayed, there is no proper medical record, post-operative care is not monitored, or known complications are ignored.

Burden of Proof in Medical Negligence Cases

In medical negligence suits, the burden of proof assumes a central importance in deciding liability. As medical science is premised on complex professional judgments, the proof of negligence tends to be more complicated than in run-of-the-mill civil cases. The complainant has to establish that the healthcare professional did not exercise the reasonable standard of skill, care, and diligence that would be expected of a reasonably competent medical professional in the given situation.

Plaintiff's Burden to Prove Negligence

In general principles of law, the onus rests with the plaintiff (or complainant) who makes a claim of negligence. The patient has to prove three key things:

1. Duty of care owed by the medical practitioner;
2. Failure in the duty through an act or omission that fell below the expected standard;
and
3. Resulting injury or damage caused directly by the breach.

In consumer grievances, the patient has to establish that the conduct of the physician was different from standard medical practices and that such departure caused injury. The Supreme Court, in *Jacob Mathew v. State of Punjab* (2005), had pointed out that not all untoward medical results constitute negligence. A physician can be held liable only if their conduct falls below the reasonable level of competence of a normal competent practitioner exercising ordinary care.

Additionally, the Court warned against the presumption of negligence simply because the treatment was ineffective. Medicine is an uncertain art; therefore, the burden on the complainant is to prove a clear link between the act of the doctor and the harm caused. Emotional distress or mere allegations cannot take the place of reliable proof.

Role of Expert Medical Evidence

Due to the technical nature of medical procedures, professional medical testimony is frequently

essential to establish whether or not negligence took place. Expert opinion is used by courts and consumer forums to determine whether the treatment or diagnosis was consistent with accepted medical practice at the time it occurred.

The importance of expert opinion was realized in *Kusum Sharma v. Batra Hospital* (2010), wherein the Supreme Court found that claims of medical negligence have to be substantiated by cogent and authoritative expert evidence. Expert witnesses bridge the gap between the lay perception of law and the scientific subtleties of medicine. Their testimony aids the adjudicating body to ascertain whether the physician behaved with reasonable competence or fell into a professional error.

But although expert evidence is highly persuasive, it is not conclusive. The forum has to still consider the whole factual scenario, hospital reports, and behavior of the parties in order to arrive at a just conclusion.

Doctrine of Res Ipsa Loquitur – “The Thing Speaks for Itself”

The principle of res ipsa loquitur is a piece of evidence in special cases of medical negligence. Literally translating to “the thing speaks for itself,” it provides the court with the facility to conclude negligence from the inherent nature of the accident even if there is no direct evidence.

This doctrine comes into play when:

1. The injury would not normally happen without negligence;
2. The instrument or act of causing harm was within the exclusive control of the medical practitioner; and
3. The patient did not contribute to the harm.

For instance, a piece of surgical equipment left within the patient’s body or incorrect limbs being operated on are instances wherein facts themselves determine negligence without necessarily necessitating elaborate expert testimony. Under such circumstances, the onus will be on the doctor or hospital to account for how the event happened despite due care.

Yet, courts warned that res ipsa loquitur had to be used sparingly. *Achutrao Haribhau Khodwa*

v. State of Maharashtra (1996) held by the supreme Court that the doctrine could assist in

inferences where the case was obvious, yet it could not be applied to infer negligence in complicated or contentious medical situations. Every case had to be looked into in view of its own facts and evidence.

Judicial Interpretation and Landmark Case Laws

Judicial pronouncements have also been instrumental in determining the contours of medical negligence law in India, particularly in the context of the Consumer Protection Act (CPA). Through a series of landmark cases, the judiciary has increasingly spelled out how the principles of negligence, duty of care, and consumer rights converge with medical practice. Every case has helped shape the benchmark of accountability of medical practitioners and hospitals in a way that secures the rights of patients as consumers.

Indian Medical Association v. V.P. Shantha (1995) 6 SCC 651

(Extension of Medical Services under the Consumer Protection Act)

This historic verdict of the Supreme Court of India set the stage for inclusion of medical services in the domain of the Consumer Protection Act, 1986. The issue was whether a patient could be treated as a “consumer” and whether medical services could be categorized under “services” according to Section 2(1)(o) of the Act. The Court ruled that medical professionals and hospitals offering services for consideration (payment) are included in the definition of “service” under the CPA. Free services and services under a contract of personal service (such as employer–employee) were not included. This ruling was revolutionary — it made the doors available to patients to claim redressal for medical negligence at consumer forums, which were faster and more convenient than conventional civil courts. It laid down the doctrine that medical responsibility is not only professional but consumer-oriented as well and is focused on patients’ right to safe and capable medical care.

Spring Meadows Hospital v. Harjol Ahluwalia (1998) 4 SCC 39

(Vicarious Liability of Hospitals and Duty of Care)

This case reaffirmed the vicarious liability of hospitals for the negligence of their doctors,

nurses, and staff. The case concerned a child, Harjol Ahluwalia, who was inflicted with severe brain damage as a result of negligence in post-injection treatment in a well-known hospital. The Supreme Court held the doctor and the hospital both liable together, holding that hospitals are responsible for employing competent personnel and maintaining proper supervision and procedures. It was also noted that parents or guardians were also consumers for purposes of the Act and could claim compensation for their child's suffering. This case was a landmark in acknowledging institutional responsibility. It brought to light the fact that medical negligence isn't just a failure on an individual doctor's part, but can even be a consequence of systemic failure within hospitals, like incompetent management, inadequate facilities, or untrained staff.

Jacob Mathew v. State of Punjab (2005) 6 SCC 1

(Standard of Care and Criminal Negligence in Medical Practice)

In this significant judgment, the Supreme Court dealt with the criminal responsibility of physicians under Section 304A of the Indian Penal Code for causing deaths owing to alleged medical negligence. The case pertained to the death of a patient as a result of an oxygen cylinder malfunction during treatment. The Court underlined the point that mere negligence or a mistake of judgment does not equate to criminal negligence. The negligence has to be "gross" or extremely high in degree, meaning recklessness or complete disregard for a patient's life and safety, in order for a physician to be held criminally liable. The Court also reaffirmed the Bolam Test, stating that where a doctor is acting within a practice accepted as proper by a responsible body of medical practitioners, he cannot be negligent because it is possible to find another better practice. This ruling serves to level the scales — protecting patients from actual negligence while also safeguarding doctors against vexatious or malicious criminal prosecution that might dissuade honest practice.

Kusum Sharma v. Batra Hospital & Medical Research Centre (2010) 3 SCC 480

(Balancing Patient Rights and Doctors' Protection)

Here, the Supreme Court set forth elaborate guidelines to assess medical negligence so that it is fair and consistent. The Court noted that the doctor-patient relationship is one based on trust, and each patient looks forward to having a reasonable level of care, skill, and diligence from doctors.

The Court established that:

- A medical practitioner has to apply a reasonable degree of skill and knowledge to his work.
- The standard of care is that of an ordinary competent person exercising ordinary skill in that profession.
- Merely because a treatment was unsuccessful or a better alternative existed does not establish negligence.
- Doctors should not be judged with the benefit of hindsight.

This judgment harmonized the right to health and safety of patients with the professional autonomy and dignity of doctors, promoting judicial restraint and reasoned evaluation in medical negligence claims.

V. Kishan Rao v. Nikhil Super Speciality Hospital (2010) 5 SCC 513

(Consumer Protection in Clinical Negligence and Expert Evidence)

This was a landmark judgment in explaining the use of expert evidence in consumer complaints against medical negligence. The respondent hospital argued that the case of the complainant could not be heard without expert medical opinion. But the Supreme Court ruled that expert evidence cannot be made compulsory in all cases. Where the facts are clear and negligence is evident on the face of the record, the consumer forum can rule without recourse to medical experts. This decision streamlined the litigation process and made justice more within reach of patients by avoiding unnecessary procedural obstacles. It reaffirmed the consumer-friendly character of the CPA so that technicalities do not stand in the way of justice when negligence is apparent.

Balram Prasad v. Kunal Saha (2014) 1 SCC 384

(Record-Breaking Compensation and Accountability of Medical Institutions)

This case became a milestone in Indian legal and medical history. The wife of Dr. Kunal Saha, Anuradha Saha, died of gross medical negligence in Kolkata. In a comprehensive review of

facts and expert evidence, the Supreme Court granted a record compensation of ₹6.08 crore (with interest) — one of the highest in Indian legal history. The Court held that the hospital and doctors were grossly negligent, mainly in the administration of an overdose of steroids, which resulted in lethal complications. The judgment emphasized that individual practitioners as well as institutions have to uphold the highest standards of professional vigilance.

In addition to compensation, the case had profound repercussions. It delivered a resounding message on medical responsibility, ethical obligation, and institutional accountability, as well as challenging hospitals to improve internal requirements and patient care mechanisms.

Remedies and Compensation under the Consumer Protection Act

Kinds of Compensation under the CPA

Consumer forums at the National, State, and District levels under the CPA are authorized to grant various kinds of remedies based on the injury caused. These most frequently awarded include:

- **Monetary Damages:**Including the payment for hospitalization, treatment, rehabilitation, and any other medical expenses arising out of negligent behavior.
- **Reimbursement or Refund:**Directed in cases where the patients have made payments for low-quality or unsuccessful medical care.
- **Compensation for Pain and Suffering:**Recognizing the emotional trauma and mental distress resulting from below-standard medical treatment.
- **Compensation for Loss of Income or Earning Capacity:**Particularly relevant where negligence leads to long-term disability, unemployment, or diminished earning capacity.
- **Punitive or Exemplary Damages:**Infrequently imposed, but applied in instances of gross or willful negligence for the purpose of discouraging similar behavior among professionals.

National Commission and Supreme Court's role in Determining Compensation

The National Consumer Disputes Redressal Commission (NCDRC) and Supreme Court of

India are instrumental in developing a just criterion to ascertain compensation in cases of medical negligence.

In *Balram Prasad v. Kunal Saha*, the Supreme Court ordered a record compensation of more than ₹6 crores the largest in Indian judicial history for medical negligence. The Court noted that compensation should be “just, fair, and commensurate with the magnitude of the wrong” (*Balram Prasad v. Kunal Saha*, 2014). The case shifted away from token awards to realistic and fair compensation based on both pecuniary and non-pecuniary damages.

In *Spring Meadows Hospital v. Harjol Ahluwalia* (1998), the Supreme Court held that hospitals are liable vicariously for the negligent acts of their employees. It stressed that the compensation must put the victim in the position they would have been in if the negligence had not taken place.

The NCDRC, too, adopts a systematic approach taking into account the level of negligence, extent of injury, earning capacity, future suffering, and social conditions of the victim. Appellate oversight is provided by the Supreme Court to ensure uniformity and justice in the process of quantification.

Principles Guiding the Calculation of Compensation

While deciding compensation, the consumer courts follow both legal and equitable principles to provide justice in its real sense. The following factors are generally taken into consideration:

1. Nature and Extent of Injury:

Permanent disability, loss of life, or prolonged physical suffering commands greater compensation.

2. Loss of Earnings and Future Prospects:

The court calculates probable loss of earnings or loss of opportunities due to the injury.

3. Pain, Suffering, and Emotional Distress:

Non-pecuniary damages cover trauma, humiliation, or loss of quality of life.

4. Medical Costs and Future Care Fees:

Covers costs of continued treatment, prosthetics, nursing, or rehabilitation assistance.

5. Age and Socioeconomic Status:

The younger victim or dependents of the deceased receive higher compensation.

6. Extent of Negligence:

Willful, reckless, or gross negligence incurs greater and sometimes punitive damages.

These ideals guarantee that remuneration not only repairs monetary loss but also recognizes suffering and professional responsibility — a foundation of consumerist justice.

Defences Available to Medical Practitioners under Consumer Law

While the Consumer Protection Act (CPA) identifies the rights of patients as consumers, it similarly provides protection to medical professionals against frivolous or unwarranted claims. Doctors are not guarantors of success but are required to practice reasonable care, skill, and diligence in accordance with the profession's standards. The legislation thus balances patients' protection with the protection of medical professionals' professional independence.

Lack of Negligence / Reasonable Standard of Care

The first defence to which a medical professional is entitled is the lack of negligence, proven by evidence demonstrating that due care and caution have been exercised in keeping with accepted medical practice.

In *Jacob Mathew v. State of Punjab*, the Supreme Court held that a medical practitioner would not be liable simply because something went wrong or there was a mistake in judgment, as long as the treatment was by a practice accepted by a responsible body of medical opinion. The Court established that negligence cannot be presumed and that a doctor is not liable criminally unless there is gross negligence or recklessness (*Jacob Mathew v. State of Punjab*, 2005).

This is in accordance with the Bolam Test, which holds that a doctor is not negligent if his act is backed by a “responsible body of medical opinion” although other practitioners may have a different practice.

Error of Judgment

Not all failed treatments constitute negligence. Courts have always held that a mistake of judgment is not always medical negligence, especially when such judgment is made after exercising due diligence.

In *Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole* (1969), the Supreme Court held that a doctor cannot be held negligent merely because his line of treatment was not successful, provided that it was a reasonable and proper course under the given circumstances.

Consent and Informed Choice

Another significant defence is that the patient gave permission for the procedure or treatment after being made aware of the risks involved. Informed consent acts as a defence for health professionals whereby the patient willingly consents to treatment following comprehension of its possible implications.

But consent has to be free, voluntary, and informed. In *Samira Kohli v. Dr. Prabha Manchanda* (2008), the Supreme Court ruled that operating on a patient without the latter’s consent (other than in the case of emergency to save the person’s life) is an assault and negligence. On the other hand, where informed consent is taken, the physician cannot be held responsible for complications due to known risks involved in the procedure.

Contributory Negligence by the Patient

When the patient’s own negligence is the cause of the harm, the doctor’s liability can be diminished or even eliminated.

Examples of contributory negligence include failure to comply with post-operative directions, failing to take prescribed medications, or hiding pertinent medical history.

In *Kavita Devi v. Poswal Nursing Home* (2010), the National Commission noted that patients also have a duty of care to themselves and are required to abide by medical advice.

Compensation can accordingly be diminished proportionately where the patient's conduct increases the injury.

Emergency or Life-Saving Situations

In emergencies, physicians are frequently called upon to act in a flash under pressure. The courts understand that acts done in good faith in emergencies with the purpose of saving life cannot be viewed as negligence simply because the results were adverse. Section 88 of the Indian Penal Code, 1860, also gives statutory protection to acts done in good faith for the benefit of another individual even if they cause harm provided consent is obtained or the act is otherwise justified by circumstances.

Reliance on Expert Opinion

A good defense for healthcare professionals is expert evidence affirming that the treatment conformed to the standard care. In *Kusum Sharma v. Batra Hospital & Medical Research Centre* (2010), the Supreme Court highlighted the need for expert medical opinion before arriving at the conclusion of negligence. The Court cautioned that consumer forums should not jump to conclusions to find negligence without medical assessment and professional advice.

Lack of Causation

Even if there is evidence that there was a breach of duty, the physician can escape liability in case it is established that what happened was not a direct consequence of the alleged negligence. The plaintiff needs to prove a direct link between the wrongful act and injury caused. If the injury is caused by an unrelated pre-existing condition or by a complication that was not the fault of the doctor, the defence of lack of causation holds good.

Good Faith and Professional Conduct

Medical professionals are being shielded under Section 3 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, which call for them to perform in good faith. Such a medical professional who is performing honestly, reasonably skillfully, and professionally with high integrity, and without any ulterior motive, has a legitimate claim to the defence of good faith.

Where and How to Approach for Redressal of Medical Negligence under the Consumer Protection Act, 2019

Patients who are harmed due to medical negligence can seek redressal under the Consumer Protection Act, 2019 (CPA, 2019) through the Consumer Disputes Redressal Commissions at the District, State, and National levels. These adjudicating bodies offer a convenient and economic platform for dispute redressal in matters of medical services. A complaint may be filed by the aggrieved patient, their legal heir or representative, a recognized consumer association, or even by the Central or State Government in the interest of consumers. The jurisdiction of the above-mentioned commissions is based on the value of the claim — the District Commission decides cases up to ₹50 lakh, the State Commission resolves claims between ₹50 lakh and ₹2 crore, and the National Commission decides cases above ₹2 crore, according to Sections 34, 47, and 58 of the CPA, 2019.

To make a complaint, the consumer has to draft a written statement listing the parties' names and addresses, facts that comprise the cause of action, the nature of service deficiency, and the amount of compensation claimed. The complaint is to be supported by supporting evidence in the form of medical reports, prescriptions, hospital bills, expert's opinions, and any communication with the doctor or hospital. The complaint can be submitted physically to the commission office or electronically by using the government's official portal e-Daakhil, which facilitates online registration, uploading of documents, and tracking of hearings. The commissions are made to facilitate ease in process and minimal procedural formalities so that justice is made easily accessible to common citizens.

Fees and Procedure for Filing a Complaint

The filing fee for consumer complaints under the Consumer Protection (Fee for Filing Complaint and Miscellaneous Provisions) Rules, 2018 is intentionally kept low to promote accessibility. The amount varies according to the compensation claimed: no fee is charged for claims up to ₹5 lakh, while it gradually increases to ₹5,000 for claims exceeding ₹2 crore. The payment of the fee may be made online via the e-Daakhil portal or by demand draft in favor of the respective Consumer Commission. Upon submission, the commission reviews if the complaint is admissible and, if so, issues notice to the opposing party (the doctor or hospital). Both parties have chances to produce evidence and arguments. The commissions are mandated to dispose of cases in three months from the date of admission if there is no laboratory report

involved, and in five months if there is laboratory report involved, to provide timely justice. The procedure is based on tenets of natural justice instead of severe procedural codes, so it is consumer-centric and less threatening for patients approaching redress.

Reliefs and Compensation Available

After proving negligence, the Consumer Commission is authorised under Section 39 of the Consumer Protection Act, 2019 to grant an assortment of reliefs. These involve refund of charges, recovery of medical bills, and compensation for bodily suffering, mental anguish, loss of wages, or permanent disability incurred by reason of the negligent act. In rare cases, the Commission can also award punitive damages to deter future negligence or order the hospital to provide corrective advertisements or apologies to reestablish the dignity of the patient. Both the Supreme Court of India and the National Consumer Disputes Redressal Commission (NCDRC) have stressed that the compensation should be reasonable, fair, and proportionate to the injury suffered, considering the patient's age, earning capacity, nature of injury, and effect on the life expectancy. The leading case *Balram Prasad v. Kunal Saha* (2014) 1 SCC 384 continues to be the guiding case, where the Supreme Court ordered the biggest-ever compensation in a case of medical negligence, reaffirming the fact that accountability in health care is essential for upholding public confidence in the medical profession.

Appellate Remedies

Consumer Protection Act also ensures a systematic scheme of appeals to ensure equity and surveillance. If one party is aggrieved by the State Commission's order, an appeal may be filed before the State Commission within 45 days. State Commission orders may be appealed before the National Commission, and subsequently, before the Supreme Court of India within 30 days of the order. The appellate forums can affirm, alter, or set aside the findings of the lower commissions. One of the notable aspects of the 2019 Act is that appeals in frivolous cases are discouraged, and the appellant is even asked to deposit a part of the compensation given by the lower forum as a precondition to hearing the appeal. It provides for both accessibility and accountability in the utilization of appellate remedies.

Conclusion

Medical negligence remains a multifaceted and dynamic subject of the law that requires a

delicate balance between ensuring the rights of patients and maintaining the professional independence of medical professionals. The Consumer Protection Act, 2019 has consolidated the infrastructure of accountability by ensuring accessible and organized mechanisms of redressal of grievances due to medical negligence. Through pathbreaking judgments like *Indian Medical Association v. V.P. Shantha* and *Balram Prasad v. Kunal Saha*, the courts have broadened the interpretation of "service" to cover medical services and raised the standards of medical accountability. Concurrently, courts have pushed for safeguarding doctors from unwarranted or unsubstantiated complaints, as stressed in *Jacob Mathew v. State of Punjab* and *Kusum Sharma v. Batra Hospital*.

The developing jurisprudence emphasizes that negligence cannot be assumed just because a treatment goes awry or a patient succumbs; instead, it needs to be proved through authentic evidence and strict adherence to the Bolam test and expert consensus. The compensation process under the Act provides not only financial reparation but also moral and social justice to victims of medical negligence. As medicine becomes increasingly commercialized, the priority on ethical practice, informed consent, and patient safety becomes even more important. In the end, the law seeks to develop a healthcare system based upon trust, competence, and accountability—and ensure that justice benefits patients and physicians alike.

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Landmark judgment where the Supreme Court held that medical services fall under “service” as defined in the Consumer Protection Act, 1986.

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Established the principle of vicarious liability of hospitals for acts of their doctors.

- Jacob Mathew v. State of Punjab, (2005) 6 SCC 1 (India).

Clarified the standard of care for medical negligence and distinguished between civil and criminal liability.

- Kusum Sharma v. Batra Hospital & Medical Research Centre, (2010) 3 SCC 480 (India).

Reiterated the need to balance patient rights with the protection of doctors from frivolous litigation.

- V. Kishan Rao v. Nikhil Super Speciality Hospital, (2010) 5 SCC 513 (India).

Simplified procedural aspects and emphasized patient protection under the CPA.

- Balram Prasad v. Kunal Saha, (2014) 1 SCC 384 (India).

The Supreme Court awarded record compensation for medical negligence, emphasizing accountability and patient rights.

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